

December 1, 2005
Montana Medicaid Notice
Physicians, Mid-Level Practitioners,
and Pharmacy Providers

Prior Authorization Requirements for Rozerem[®] and Lunesta[®]

Effective Immediately

Prior Authorization for Rozerem[®]

Payment for Rozerem[®] (ramelteon) will be authorized upon trial and therapy failure with at least **two** multi-source medications, prescribed for sleep, from the following list:

- Tricyclic Antidepressants
- Benzodiazepines
- Antihistamines
- Mirtazapine
- Trazodone

► Approvals will be for a **maximum 15 tablets per month.**

Prior Authorization for Daily Use of Lunesta[®] or Rozerem[®]

Payment will be considered for daily use of Rozerem[®] (ramelteon) or Lunesta[®] (eszopiclone) based upon documented clinical information and a diagnosis of “Chronic Insomnia.” Patients are required to be treated with prerequisite drug therapy for at least three consecutive months to be considered for daily use. Prerequisite therapy includes at least two months of multi-source medications, prescribed for sleep, and an initial 15-dose trial of either Lunesta[®] or Rozerem[®]. A special PA form is available at the end of this notice.

► Approvals will be for **30 tablets per month.**

The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

Drug Prior Authorization Unit
Mountain Pacific Quality Health Foundation

3404 Cooney Drive
Helena, MT 59602
(406) 443-6002 or (800) 395-7961 (Phone)
(406) 443-7014 or (800) 294-1350 (Fax)

To request prior authorization, providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form can be copied from page 5.9 of the Medicaid Prescription Drug Program Manual on the web at: <http://www.dphhs.state.mt.us/hpsd/medicaid/medicaid2/pdf/pharmacy.pdf>

Any questions regarding this notice can be directed to Dan Peterson at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

Contact Information

For claims questions or additional information, contact Provider Relations:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837

Visit the Provider Information website:

<http://www.mtmedicaid.org>



Mountain-Pacific Quality Health Foundation

3404 Cooney Drive, Helena, MT 59602
Phone (406) 443-6002 - Toll Free Phone 1-800-395-7961
Fax (406) 443-7014 - Toll Free Fax 1-800-294-1350

*"The best quality
health care is provided to
every patient we serve,
every time."*

Prior Authorization Request Form for Daily Use of Lunesta® (eszopiclone) or Rozerem® (ramelteon)

1. Patient's Name: _____ 2. Date: _____
3. I. D. Number: _____ 4. D.O.B: _____
5. Physician's Name: _____
6. Physician's Phone # _____ 7. Physician's Fax Number: _____
8. Dose Request: _____ (mg) 9. Daily Directions: _____ (Ex: 1 QD)

Please answer the following questions by checking yes or no:

EVIDENCE	YES	NO	COMMENTS BY PROVIDER
10. Is the patient 18 years or older?			
11. Is the patient currently taking a stimulant medication (ex: methylphenidate, Concerta, Adderall XR, Focalin, Strattera, Xyrem, Provigil) to promote wakefulness during the day?			
12. Is the diagnosis documented as "chronic insomnia"?			
13. Has the patient had symptoms of difficulty falling asleep, frequent nocturnal awakenings or early awakenings for at least three nights per week for three consecutive months?			
14. Has the patient failed a reasonable drug regimen to at least two multi-source medications, prescribed for sleep, from the following list? Tricyclic Antidepressants Mirtazapine Benzodiazepines Trazodone Antihistamines			PA Unit will verify patient's prescription history
15. Has the patient failed a reasonable regimen of two multi-source medications (a minimum of 2 months) in addition to at least a 1 month trial of an approved quantity (15 tablets) of the requested drug?			Required
16. If YES to 14, please list the two most recent agents prescribed:	1. _____	2. _____	

17. Signature of Physician: _____

Important Notice

The attached information is **CONFIDENTIAL** and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution or copying of the communication is strictly prohibited. Anyone who receives this in error should notify us immediately by telephone, *toll-free at (800) 395-7961 or locally at 406-443-6002* and return the original message to us at the address above via U. S. Mail.